

STATE OF MINNESOTA  
OFFICE OF ADMINISTRATIVE HEARINGS  
FOR THE COMMISSIONER OF HEALTH

In the Matter of an Assessment Issued  
to Wendigo Pines Assisted Living and  
Memory Care on May 5, 2011, for  
Noncompliance with Correction Order  
Issued on November 18, 2010

**FINDINGS OF FACT,  
CONCLUSIONS AND  
RECOMMENDATION**

This matter came on for hearing before Administrative Law Judge Barbara L. Neilson on August 30, 2011, at the Office of Administrative Hearings in St. Paul, Minnesota. The hearing record closed at the conclusion of the hearing on that day.

Jocelyn F. Olson, Assistant Attorney General, appeared on behalf of the Department of Health (the Department). Raisa Kotula, the owner and administrator of the Licensee, Wendigo Pines Assisted Living and Memory Care, appeared on behalf of the Licensee.

**STATEMENT OF THE ISSUES**

The issue presented in this case is whether the Department properly assessed civil penalties of \$1,900 against the Licensee in May of 2011 for noncompliance with a correction order issued by the Department in November 2010.

Based on the evidence in the hearing record, the Administrative Law Judge makes the following:

**FINDINGS OF FACT**

**Background and Procedural Findings**

1. The Licensee, Wendigo Pines Assisted Living and Memory Care, Inc., is licensed by the Department to operate Wendigo Pines Assisted Living (Wendigo Pines) as a Class F Home Care Provider. Under the license, the Licensee may provide home care services solely for residents of housing with services establishments registered pursuant to Minn. Stat. § Chapter 144D.<sup>1</sup>

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<sup>1</sup> Exhibit (Ex.) 2; Testimony (Test.) of Sharon Szamatula.

2. The administrator and owner of Wendigo Pines is Raisa Kotula. Ms. Kotula is a registered nurse who received her Minnesota license in 2003. Wendigo Pines has approximately 30 employees.<sup>2</sup>

3. Wendigo Pines specializes in caring for senior citizens who have dementia. It has four separate houses on twenty acres in Grand Rapids, Minnesota, and currently cares for a total of 30 residents. Five men and five women with mild dementia reside in the two smaller houses. Ten individuals with moderate dementia reside in the third house, and ten individuals with advanced dementia reside in the fourth house. The larger two houses can accommodate up to twelve residents. Each house is surrounded by a security fence.<sup>3</sup>

4. The Licensee's Administrator has received positive feedback from residents and their relatives during the time she has operated Wendigo Pines. She provided several letters written by residents and family members of individuals who have resided at Wendigo Pines which praised the quality of the care provided at Wendigo Pines, expressing confidence in the staff, and expressing appreciation for the kindness they show the residents.<sup>4</sup>

5. Under state law, the Department is required to monitor and inspect home care providers. When performing surveys of facilities, Department employees typically schedule an on-site visit and observe staff and clients, review documents, and conduct interviews. Correction Orders are issued if violations of applicable statutes or rules are found, and a time period is specified in which the violation must be corrected. The Department follows up later to see whether the violation has been corrected and, if not, assesses penalties in accordance with a schedule of fines set forth in Department rules.<sup>5</sup>

6. On June 7, 2010, the Department completed a survey of Wendigo Pines and found eight violations of Minnesota Statutes and rules. As a result, the Department issued Correction Orders requiring correction of those violations within a specified timeframe. On August 3, 4, 5, and 13, 2010, the Department conducted a re-inspection concerning the violations and found that five of the violations had not been corrected. On November 18, 2010, the Department assessed penalties in the amount of \$1,400 against the Licensee for the uncorrected violations.<sup>6</sup>

7. The Licensee requested a contested case hearing to challenge the November 18, 2010, assessment. The hearing was held on March 14, 2011, and, on April 13, 2011, the Administrative Law Judge issued Findings of Fact, Conclusions of Law, and a Recommendation in which she recommended that the Commissioner of Health affirm the assessment issued on November 18, 2010.<sup>7</sup> On August 31, 2011, the

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<sup>2</sup> Test. of Raisa Kotula.

<sup>3</sup> Test. of Kotula.

<sup>4</sup> Test. of Kotula; Exs. 12-17.

<sup>5</sup> Test. of Szamatula; Minn. Stat. § 144A.45, subd. 2.

<sup>6</sup> Test. of Szamatula.

<sup>7</sup> Ex. 8.

Commissioner issued an Order adopting the Report of the Administrative Law Judge with certain modifications and affirming the assessment of civil penalties in the amount of \$1,400.<sup>8</sup>

8. During the August 2010 re-inspection, the Department also found fifteen new violations of applicable Minnesota statutes and rules. On November 18, 2010, the Department issued Correction Orders requiring correction of those fifteen violations within specified time periods.<sup>9</sup>

9. The November 18, 2010, Correction Order issued to the Licensee contained the following warning:

If, upon re-survey, it is found that the violation or violations cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with the schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided in the section entitled "TO COMPLY." Where a rule contains several items, failure to comply with any of the items may be considered lack of compliance and subject to a fine.<sup>10</sup>

10. On January 31, 2011, the Department completed a second re-inspection concerning previous violations. The Department subsequently determined that seven of the fifteen violations noted in the November 18, 2010, had not been corrected.<sup>11</sup>

11. By letter dated May 5, 2011, the Department issued to the Licensee a Notice of Assessment for Noncompliance with Correction Orders for Class F Home Care Providers. In the Notice, the Department informed the Licensee that, as a result of Wendigo Pines' failure to correct seven of the fifteen licensing orders issued on November 18, 2010, the Department was assessing penalties against the Licensee in the total amount of \$1,900. The Department enclosed with the Notice copies of a Revisit Report identifying the eight state licensing orders that were found to have been corrected at the time of the January 31, 2011, re-inspection and a Statement of Deficiencies and Plan of Correction identifying the state licensing orders that were found not to have been corrected at the time of the January 31, 2011, re-inspection. As discussed more fully below, the Department determined that there were uncorrected violations of the following rule provisions: content of client record (Minn. Rules 4668.0810, subpart 6); performance of routine procedures (Minn. Rules 4668.0825, subpart 4); nursing assessment and service plan (Minn. Rules 4668.0855, subpart 2); administration of medications (Minn. Rules 4668.0855, subpart 5); renewal of orders

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<sup>8</sup> Order of the Commissioner in *In the Matter of an assessment Issued to Wendigo Pines Assisted Living and Memory Care, Inc. on November 18, 2010*, OAH Docket No. 11-0900-21813-2 (Aug. 31, 2011).

<sup>9</sup> Ex. 3.

<sup>10</sup> Ex. 3 at 1; Ex. 6 at 2.

<sup>11</sup> Ex. 6.

(Minn. Rules 4668.0860, subpart 9); assessment and service plan - central store medications (Minn. Rules 4668.0865, subpart 2) and control of medications (Minn. Rules 4668.0865, subpart 3).<sup>12</sup>

12. The Notice of Assessment advised the Licensee of its right to request a hearing to challenge the assessment. The Notice also informed the Licensee that if, upon subsequent re-inspection after a fine has been imposed, it was determined that the correction orders have not been corrected, another fine may be assessed in an amount double that of the previous fine.<sup>13</sup>

13. On May 20, 2011, the Licensee requested a contested case hearing to challenge the \$1,900 assessment.<sup>14</sup> The current contested case proceeding was thereafter initiated to consider whether this assessment was proper.<sup>15</sup>

### **Alleged Uncorrected Violations**

14. Sharon Szamatula, a registered nurse employed by the Department whose responsibilities include conducting surveys of Class F licensed facilities, conducted the re-inspection of Wendigo Pines that was completed on January 31, 2011. The purpose of the re-inspection was to determine whether state licensing orders issued on November 18, 2010 (following the survey completed in August 2010) had been corrected.<sup>16</sup>

15. As a result of the re-inspection completed on January 31, 2011, the Department concluded that the Licensee was responsible for seven uncorrected violations of applicable Minnesota rules.<sup>17</sup> These violations are described below.

#### **Minn. Rules 4668.0810, subpart 6**

16. Part 4668.0810, subpart 6, of the Department's rules applicable to Class F home care providers addresses the content of client records. The rule specifies that "[t]he client record must be accurate, up to date, and available to all persons responsible for assessing, planning, and providing assisted living home care services." Among other things, the record is required to contain: "dates of the beginning and end of services;" "medication and treatment orders, if any;" "documentation of each instance of assistance with self-administration of medication and of medication administration, if any;" "documentation on the day of occurrence of any significant change in the client's status or any significant incident, including a fall or a refusal to take medications, and any actions by staff in response to the change or incident;" "documentation at least weekly of the client's status and the home care services provided;" "a summary following the discontinuation of services, which includes the reason for the initiation and

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<sup>12</sup> Ex. 6.

<sup>13</sup> Ex. 6 at 2.

<sup>14</sup> Ex. 7.

<sup>15</sup> Ex. 1.

<sup>16</sup> Test. of Szamatula; Ex. 6.

<sup>17</sup> Ex. 6.

discontinuation of services and the client's condition at the discontinuation of services;" and "any other information necessary to provide care for each individual client."<sup>18</sup>

17. The Correction Order that the Department issued to the Licensee on November 18, 2010, included a determination that the Licensee violated Minn. Rules 4668.0810, subpart 6, by failing to maintain a complete record for four clients. The determination was based upon findings that there was no documentation in one client's record pertaining to an incident in which the client left the residence and police were called to assist in finding the client; there was no documentation in a second client's record noting that daily dressing changes had occurred; there was no discharge summary or documentation in a third client's record regarding when the client expired; and there was no documentation in a fourth client's record pertaining to when the client expired or the client's condition just prior to that time. The Correction Order gave the Licensee seven days to come into compliance with Minn. Rules 4668.0810, subpart 6.<sup>19</sup>

18. During the re-inspection completed on January 31, 2011, Ms. Szamatula concluded based on documentation review and interviews with staff that the Licensee had violated Minn. Rules 4668.0810, subpart 6, by failing to include documentation in a client's record regarding his condition prior to being sent to the emergency room. In that situation, the client's medical record included a progress note by the registered nurse which documented the client's blood pressure and pulse at the time, indicated that staff had called her to report that the client was vomiting a coffee-like substance, and stated that a 911 call was placed and the client was "sent to ER." The registered nurse told Ms. Szamatula that she had completed this progress note based on a telephone call she received from the PCA who was caring for the client at the time, and she believed the client had been transported to a hospital emergency room. During her interview with Ms. Szamatula, the PCA said that she called the registered nurse in the early morning when the client became weak and unresponsive and had a bloody emesis, and was instructed to call 911. The PCA called 911 and then returned to the client's bedside. The PCA did not complete any documentation regarding the client's change of condition. She told the investigator that the client had died by the time ambulance personnel arrived. The ambulance Prehospital Care Report also confirmed that the client was deceased when they arrived at the facility and they took the client to the morgue. The facility policy and procedure for handling medical emergencies indicated that staff should complete an incident report after a client is transported to the hospital, but no incident report was completed for this client.<sup>20</sup>

19. Due to the continued violation of Minn. Rules 4668.0810, subp. 6, found during the re-inspection completed on January 31, 2011, the Department considered the earlier citation to be uncorrected. The Department assessed a penalty in the amount of \$100 pursuant to Minn. Rules 4668.0810, subp. 8 F.<sup>21</sup>

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<sup>18</sup> Minn. Rules 4668.0810, subpart 6.

<sup>19</sup> Ex. 3 at 2-3; Test. of Szamatula.

<sup>20</sup> Ex. 6 at 12-13; Test. of Szamatula.

<sup>21</sup> Ex. 5 at 1; Ex. 6 at 1; Test. of Szamatula.

#### **Minn. Rules part 4668.0825, subpart 4**

20. Part 4668.0825, subpart 4, of the Department's rules permits unlicensed personnel to perform delegated nursing services if:

- A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;
- B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;
- C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;
- D. the procedures for each client are documented in the client's record; and
- E. the class F home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.<sup>22</sup>

21. The Correction Order issued to the Licensee on November 18, 2010, included a determination that the Licensee had violated Minn. Rules 4668.0825, subpart 4, with respect to two clients by failing to provide written instructions regarding catheter care, oxygen administration, and blood sugar checks, and by failing to have documentation that the unlicensed employees had received training from the registered nurse regarding how to provide these cares. The Correction Order gave the Licensee 14 days to come into compliance with Minn. Rules 4668.0825, subpart 4.<sup>23</sup>

22. During the re-inspection completed on January 31, 2011, Ms. Szamatula found based on observation, record review, and interview that the Licensee had violated Minn. Rules part 4668.0825, subpart 4, by failing to ensure that unlicensed staff was instructed by the registered nurse in the proper method to perform a delegated nursing procedure, had been provided with written instructions for performing the procedure, and that staff had demonstrated to the registered nurse that they were competent to perform the procedure for two clients. One client received a daily dressing change to his left heel and had ace wraps applied to both legs in the morning and taken off in the evening. Although there were written instructions for the daily dressing change to the client's left heel, there were no written instructions for how to apply the ace wraps. There was no documentation that the registered nurse had trained the unlicensed employee regarding the dressing change or application of the ace wraps, and the unlicensed employee who had changed the dressing on the client's heel and applied the ace wraps on January 20, 2010, informed the investigator that a licensed practical nurse had trained her regarding both activities. The LPN told the surveyor that the registered nurse had trained the employee on how to do dressing changes, and provided the

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<sup>22</sup> Minn. Rules part 4668.0825, subpart 4.

<sup>23</sup> Ex. 3 at 6-7; Test. of Szamatula.

surveyor with a handwritten list of names of unlicensed personnel whom she stated had been trained by the registered nurse. However, the list did not bear a date or indicate that the registered nurse had provided the training. In addition, there was no documentation in the in-service training records or elsewhere that unlicensed employees had received training regarding oxygen use from the registered nurse, and there were no written instructions relating to oxygen use in the client's record or in the residence. The Department concluded that the Licensee had violated Minn. Rules 4668.0825, subpart 4, with respect to these two clients.<sup>24</sup>

23. Due to the continued violation of Minn. Rules 4668.0825, subpart 4, found during the re-inspection completed on January 31, 2011, the Department considered the earlier citation to be uncorrected. The Department assessed a penalty in the amount of \$350 pursuant to Minn. Rules 4668.0825, subp. 6 C.<sup>25</sup>

### **Minn. Rules 4668.0855, subpart 2**

24. Part 4668.0855, subpart 2, of the Department's rules relating to the nursing assessment and service plan requires that:

For each client who will be provided with assistance with self-administration of medication or medication administration, a registered nurse must conduct a nursing assessment of each client's functional status and need for assistance with self-administration of medication or medication administration, and develop a service plan for the provision of the services according to the client's needs and preferences. The service plan must include the frequency of supervision of the task and of the person providing the service for the client according to part 4668.0845, and must be maintained as part of the service plan required under part 4668.0815.<sup>26</sup>

25. The Correction Order issued to the Licensee on November 18, 2010, included a determination that the Licensee had violated Minn. Rules 4668.0855, subpart 2, with respect to six clients because there was no evidence that a registered nurse had conducted a nursing assessment of the clients' functional status and need for assistance with medication administration. The Licensee was given 30 days to come into compliance with Minn. Rules 4668.0855, subp. 2.<sup>27</sup>

26. During the re-inspection completed on January 31, 2011, Ms. Szamatula determined based on record review and interview that the Licensee had failed to ensure that a registered nurse conducted a nursing assessment for functional status and need for assistance with medication administration for four clients. There was no documentation in the RN evaluation for these four clients that an assessment of functional status and need for assistance with medication administration had been

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<sup>24</sup> Ex. 6 at 14-16; Test. of Szamatula.

<sup>25</sup> Ex. 5 at 2; Ex 6 at 1; Test. of Szamatula.

<sup>26</sup> Minn. Rules part 4668.0855, subpart 2.

<sup>27</sup> Ex. 3 at 8; Test. of Szamatula.

performed. During an interview, the LPN stated that Wendigo Pines staff was working hard to get the assessments done but confirmed that the registered nurse had not completed these assessments for the four clients. The Department concluded that the Licensee had violated Minn. Rules 4668.0855, subpart 2, with respect to these four clients.<sup>28</sup>

27. Due to the continued violation of Minn. Rules 4668.0855, subpart 2, found during the re-inspection completed on January 31, 2011, the Department considered the earlier citation to be uncorrected. The Department assessed a penalty of \$350 pursuant to 4668.0855, subp. 10 A.<sup>29</sup>

#### **Minn. Rules 4668.0855, subpart 5**

28. Under part 4668.0855, subpart 5, of the Department's rules, an individual who meets certain requirements and has been delegated the responsibility by a registered nurse is permitted to administer regularly scheduled medications orally, by suppository, through eye drops, through ear drops, by use of an inhalant, topically, by injection, or through a gastrostomy tube. Such individuals may also administer "pro re nata" (PRN) medications (i.e., medications to be administered as necessary), provided that the administration of a PRN medication is "reported to a registered nurse either: (1) within 24 hours after its administration; or (2) within a time period that is specified by a registered nurse prior to the administration."<sup>30</sup>

29. The Correction Order issued to the Licensee on November 18, 2010, included a determination that the Licensee had violated Minn. Rules 4668.0855, subpart 5, because a client's record lacked evidence that the registered nurse was notified that PRN medications (Tylenol No. 3, Ativan, and Tylenol 500 mg. tablets) were administered to the client. The registered nurse told the surveyor at the time that unlicensed personnel were required to call her before giving PRN medications, or call the LPN if the LPN was present in the facility. The registered nurse could not remember if she was called regarding administration of the PRN medications given to this particular client in early August of 2010. The Correction Order gave the Licensee seven days to come into compliance with Minn. Rules 4668.0855, subpart 5.<sup>31</sup>

30. During the re-inspection completed on January 31, 2011, Ms. Szamatula determined based on record review and interview that the Licensee had failed to ensure that the registered nurse was notified within 24 hours or within a specified time period of the administration of a PRN medication by an unlicensed employee person. The client at issue had received Haldol and/or Tylenol No. 3 on five days in December 2010, but there was no documentation in the client's record that the registered nurse was notified that the PRN medications were administered to the client. The registered nurse, when interviewed, confirmed that the unlicensed staff was supposed to call her before giving PRN medication and acknowledged that there was no documentation that she had been

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<sup>28</sup> Ex. 6 at 16-17; Test. of Szamatula.

<sup>29</sup> Ex. 5 at 2-3; Ex. 6 at 1; Test. of Szamatula.

<sup>30</sup> Minn. Rules part 4668.0855, subp. 5.

<sup>31</sup> Ex. 3 at 8-9; Test. of Szamatula.

notified of the PRN medications administered on the dates in question. The Department concluded that the Licensee had violated Minn. Rules 4668.0855, subpart 5, with respect to this client.<sup>32</sup>

31. Due to the continued violation of Minn. Rules 4668.0855, subpart 5, found during the re-inspection completed on January 31, 2011, the Department considered the earlier citation to be uncorrected. The Department assessed a penalty in the amount of \$350 pursuant to 4668.0855, subp. 10 D.<sup>33</sup>

#### **Minn. Rules 4668.0860, subpart 9**

32. Part 4668.0860, subpart 9, of the Department's rules applicable to Class F licensees requires that "[a] medication or treatment order must be renewed at least every 12 months or more frequently as indicated by the nursing assessment required under part 4668.0855, subpart 2."<sup>34</sup>

33. The Correction Order issued to the Licensee on November 18, 2010, included a determination that the Licensee had violated Minn. Rules 4668.0860, subpart 9, because the records of two clients lacked evidence that their medication and treatment orders were reviewed by their physicians at least annually. The registered nurse asserted at the time that she was unaware of this requirement. The Licensee was given seven days to come into compliance with Minn. Rules 4668.0860, subp. 9.<sup>35</sup>

34. During the re-inspection completed on January 31, 2011, Ms. Szamatula determined based on interviews and documentation review that the Licensee had violated Minn. Rules 4668.0860, subpart 9, by failing to ensure that medication or treatment orders were renewed at least every 12 months for one client who had received services for longer than a year. That client had begun receiving services in October 2008, and her primary care physician had signed admission orders on that date. There was no evidence of annual renewal of medication or treatment orders after that date. The client saw her primary care physician in July 2010 and January 2011 and physician's orders bearing those dates were included in the client's medical record, but these documents did not list the current medications and treatments and did not reflect any order to renew medications and treatments. The LPN informed the investigator that a copy of each client's medication sheets are sent to physician appointments along with the physician's orders document. Neither the registered nurse nor the LPN was able to produce an annual renewal by the client's physician listing the client's medication and treatment orders.<sup>36</sup>

35. Due to the continued violation of Minn. Rules 4668.0860, subpart 9, found during the re-inspection completed on January 31, 2011, the Department considered

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<sup>32</sup> Ex. 6 at 18-19; Test. of Szamatula.

<sup>33</sup> Ex. 5 at 3; Ex. 6 at 1; Test. of Szamatula.

<sup>34</sup> Minn. Rules part 4668.0860, subd. 9.

<sup>35</sup> Ex. 3 at 12.

<sup>36</sup> Test. of Szamatula; Ex. 6 at 19-20.

the earlier citation to be uncorrected. The Department assessed a penalty in the amount of \$100 pursuant to Minn. Rules 4668.0860, subp. 10 K.<sup>37</sup>

36. Minn. Rules 4668.0860 clearly requires documentation that the actual prescriber of the medication has renewed medications and treatment orders.<sup>38</sup> The mere fact that clients' prescriptions were refilled by the pharmacy therefore does not meet the requirements of this rule part.

### **Minn. Rules 4668.0865, subpart 2**

37. Part 4668.0865, subpart 2, of the Department's rules requires that, "[f]or a client for whom medications will be centrally stored, a registered nurse must conduct a nursing assessment of the client's functional status and need for central medication storage, and develop a service plan for the provision of that service according to the client's needs and preferences." The service plan must include the frequency of supervision of the task and of the person providing the service for the client in accordance with Minn. Rules part 4668.0845. The service plan for central storage of medication must be maintained as part of the service plan required under Minn. Rules part 4668.0815.<sup>39</sup>

38. The Correction Order issued to the Licensee on November 18, 2010, included a determination that the Licensee had violated Minn. Rules 4668.0865, subpart 2, because there was no evidence that a registered nurse had conducted a nursing assessment of six clients' functional status and need for central storage of medications. The Licensee was given thirty days to come into compliance with Minn. Rules 4668.0865, subp. 2.<sup>40</sup>

39. During the re-inspection completed on January 31, 2011, Ms. Szamatula determined based on interviews and documentation review that the Licensee had failed to ensure that a registered nurse conducted a nursing assessment with respect to four clients regarding the clients' functional status and need for central medication storage, in violation of Minn. Rules 4668.0865, subpart 2. During an interview, the LPN confirmed that the assessments had not been completed by the registered nurse.<sup>41</sup>

40. Due to the continued violation of Minn. Rules 4668.0865, subpart 2, found during the re-inspection completed on January 31, 2011, the Department considered the earlier citation to be uncorrected. The Department assessed a penalty in the amount of \$350 pursuant to Minn. Rules 4668.0865, subp. 10 A.<sup>42</sup>

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<sup>37</sup> Ex. 5 at 3; Ex. 6 at 1.

<sup>38</sup> See, e.g., Minn. Rules 4668.0860, subp. 2 ("[t]here must be a written prescriber's order for a drug for which a class F home care provider licensee provides assistance with self-administration of medication or medication administration"); subp. 4 ("[a]n order for medication or treatment must be dated and signed by the prescriber," with certain exceptions for verbal and electronic orders).

<sup>39</sup> Minn. Rules part 4668.0865, subp. 2.

<sup>40</sup> Ex. 3 at 12-13.

<sup>41</sup> Test. of Szamatula; Ex. 6 at 21-22.

<sup>42</sup> Ex. 5 at 3-4; Ex. 6 at 1.

### **Minn. Rules 4668.0865, subpart 3**

41. Part 4668.0865, subpart 3, of the Department's rules specifies that a registered nurse or pharmacist "must establish and maintain a system that addresses the control of medications, handling of medications, medication containers, medication records, and disposition of medications." The rule part goes on to state that the system must contain at least the following provisions:

- (1) a statement of whether the staff will provide medication reminders, assistance with self-administration of medication, medication administration, or a combination of those services;
- (2) a description of how the distribution and storage of medications will be handled, including a description of suitable storage facilities;
- (3) the procedures for recording medications that clients are taking;
- (4) the procedures for storage of legend and over-the-counter drugs;
- (5) a method of refrigeration of biological medications; and
- (6) the procedures for notifying a registered nurse when a problem with administration, record keeping, or storage of medications is discovered.<sup>43</sup>

42. The Correction Order issued to the Licensee on November 18, 2010, included a determination that the Licensee had violated Minn. Rules 4668.0865, subpart 3, because expired medications were noted in the medication cupboards in three of the residences. The expired medications were a jar of vaporizing colds rub with an expiration date of May 2007, two bottles of anti-diarrheal pills with expiration dates of January 2010 and June 2010, a bottle of liquid antacid with an expiration date of January 2010, a tube of Aspercreme with an expiration date of July 2009, two tubes of Vitamin A & D ointment with expiration dates of April 2010 and July 2010, one bottle of stool softener with an expiration date of July 2009, and a bottle of aspirin with an expiration date of August 2010. When interviewed, the registered nurse stated that the house managers were to check periodically to see if medications had expired. The Licensee was given seven days to come into compliance with part 4668.0865, subp. 3.<sup>44</sup>

43. During the re-inspection completed on January 31, 2011, Ms. Szamatula determined based on interview and observation that the Licensee had failed to establish and maintain a system to ensure that medications were not used after their expiration dates in one of the Licensee's four residences, in violation of Minn. Rules 4668.0865, subpart 3. Specifically, on January 26, 2011, several expired medications were noted in the medication cupboard in one of the Licensee's four buildings. The medications at issue were a jar of medicated chest rub with an expiration date of November 2010, a

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<sup>43</sup> Minn. Rules part 4668.0865, subp. 3.

<sup>44</sup> Ex. 3 at 13; Test. of Szamatula.

tube of hydrocortisone cream with an expiration date of August 2010, and a bottle of 70% Isopropyl Alcohol with an expiration date of December 2009. The registered nurse confirmed during her interview that the medications were expired.<sup>45</sup>

44. Due to the continued violation of Minn. Rules 4668.0865, subpart 3, found during the re-inspection completed on January 31, 2011, the Department considered the earlier citation to be uncorrected. The Department assessed a penalty in the amount of \$300 pursuant to Minn. R. 4668.0865, subp. 10 B.<sup>46</sup>

Based upon the Findings of Fact, the Administrative Law Judge makes the following:

### **CONCLUSIONS**

1. The Commissioner and the Administrative Law Judge have authority to consider the alleged violations by the Licensee pursuant to Minn. Stat. §§ 14.50 and 144A.45, subd. 2(a)(4).

2. The Licensee received timely and appropriate notice of the charges against it and the time and place of the hearing.

3. The Commissioner has complied with all relevant substantive and procedural requirements of statute and rule.

4. The Department of Health has the burden to establish the validity of its claims in this case by a preponderance of the evidence.<sup>47</sup>

5. The Department of Health is required to conduct inspections and re-inspections of home care providers such as assisted living facilities.<sup>48</sup> A provider that receives a correction order must be re-inspected at the end of the period allowed for correction and, if it is determined that the provider has not corrected a violation identified in the correction order, the Department must issue a notice of noncompliance with the correction order that specifies the violations not corrected and the fines assessed.<sup>49</sup>

6. Minn. Stat. § 144.653, subd. 6, specifies that fines must be assessed in accordance with a schedule of fines established by the Commissioner of Health. The Commissioner has promulgated rules that set forth the schedule of fines for uncorrected violations.

7. The Department demonstrated by a preponderance of the evidence that it properly issued a Correction Order on November 18, 2010, finding that Wendigo Pines had violated Minnesota Rules 4668.0810, subp. 6; 4668.0825, subp. 4; 4668.0855,

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<sup>45</sup> Ex. 6 at 23; Test. of Szamatula.

<sup>46</sup> Ex. 5 at 4; Ex. 6 at 1; Test. of Szamatula.

<sup>47</sup> Minn. R. 1400.7300, subp. 5.

<sup>48</sup> Minn. Stat. §§ 144A.45, subd. 2, and 144A.53, subd. 1.

<sup>49</sup> Minn. Stat. § 144.653, subd. 6.

subps. 2 and 5; 4668.0860, subp. 9; and 4668.0865, subp. 2; and that it properly found that Wendigo Pines had failed to correct these violations by the time of the Department's re-inspection in January 2011. The Department has demonstrated that the penalties assessed against the Licensee for these uncorrected violations were authorized by rule and are in the public interest.<sup>50</sup>

8. The Department failed to demonstrate by a preponderance of the evidence that it properly issued a Correction Order on November 18, 2010, finding that Wendigo Pines had violated Minnesota Rules 4668.0865, subp. 3, or that it properly found that Wendigo Pines had violated that rule provision at the time of its re-inspection in January 2011. The Department has not demonstrated a proper basis for imposition of a penalty for violation of Minnesota Rules 4668.0865, subp. 3.

9. The attached Memorandum further explains the reasons for these Conclusions and is incorporated in these Conclusions.

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

### RECOMMENDATION

IT IS HEREBY RECOMMENDED: That the Department's assessment against Wendigo Pines be **AFFIRMED** with respect to Minnesota Rules 4668.0810, subp. 6; 4668.0825, subp. 4; 4668.0855, subps. 2 and 5; 4668.0860, subp. 9; and 4668.0865, subp. 2; and **RESCINDED** with respect to Minnesota Rules 4668.0865, subp. 3.

Dated: January 17, 2012

s/Barbara L. Neilson

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BARBARA L. NEILSON  
Administrative Law Judge

Reported: Digitally Recorded; No Transcript Prepared.

### NOTICE

This Report is a recommendation, not a final decision. The Commissioner of the Minnesota Department of Health will make the final decision after a review of the record. The Commissioner may adopt, reject, or modify the Findings of Fact, Conclusions, and Recommendations contained herein. Pursuant to Minn. Stat. § 14.61, the final decision of the Commissioner shall not be made until this Report has been made available to the parties to the proceeding for at least ten days and an opportunity has been afforded to each party adversely affected to file exceptions and present argument to the Commissioner. Parties should contact the Office of the Commissioner of Health, 85

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<sup>50</sup> The schedule of fines applicable to the violations alleged in this matter is set forth in Minn. Rules parts 4668.0810, subpart 8 F; 4668.0825, subpart 6 C; 4668.0855, subpart 10 A and D; 4668.0860, subpart 10 K; and 4668.0865, subpart 10 A.

East Seventh Place, Suite 400, St. Paul, Minnesota 55101, telephone (651) 201-5000, to learn the procedure for filing exceptions or presenting argument.

If the Commissioner fails to issue a final decision within 90 days of the close of the record, this report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a. The record closes upon the filing of exceptions to the report and the presentation of argument to the Commissioner, or upon the expiration of the deadline for doing so. The Commissioner must notify the parties and the Administrative Law Judge of the date on which the record closes.

Under Minn. Stat. § 14.62, subd. 1, the agency is required to serve its final decision upon each party and the Administrative Law Judge by first class mail or as otherwise provided by law.

### **MEMORANDUM**

The Administrative Law Judge has concluded that the Department has shown a proper basis for its determination that six of the rule violations that were found to have occurred at Wendigo Pines in November 2010 were uncorrected as of the re-inspection in January 2011, and the penalties assessed based on these violations were appropriate. Many of the violations involved the lack of required documentation in client records and employee files. The Department provided testimony and exhibits explaining why it determined that those violations occurred, and the Licensee did not supply the missing documentation at the hearing despite having the opportunity to do so.

Those licensed to provide home care are expected to know and comply with the Department's rules, and it is apparent that the rules are designed not only to ensure the provision of necessary and appropriate care to residents but also provide a written record to facilitate the Department's oversight. There can be no question regarding the importance of requiring that unlicensed personnel have received appropriate training by a registered nurse and are provided with written instructions to which they can refer before they perform delegated nursing procedures, and it is appropriate that Department surveyors enforce the rules requiring that such documentation be maintained. Due to the potential for drug interactions, it is also important to ensure that unlicensed staff have notified the RN when PRN medications have been given and to require documentation to that effect. The additional requirements that licensees document changes in condition of a resident, obtain renewals of medication and treatment orders at least annually, and assess residents' functional status and their need for medication assistance and centralized storage are obviously important in serving the needs of residents. While, as the Licensee pointed out, it may be the case that those residing in locations that specialize in dementia care may not be capable of self-administering medication, the rule appropriately requires the nurse to perform an individualized assessment rather than make a blanket assumption based on formal diagnosis.

The Administrative Law Judge has recommended that the penalty imposed for alleged violation of Minn. Rules 4668.0865, subp. 3, be rescinded. The relevant portion of subpart 3 simply requires that a registered nurse or pharmacist "establish and

maintain a system that addresses the control of medications, handling of medications, medication containers, medication records, and disposition of medications.” The mere fact that some expired over-the-counter medications were found in the medication cupboard, without more, does not support a finding that this subpart has been violated. The language of the rule does not provide adequate notice to licensees that it is intended to require them to adopt a formal schedule for review of expiration dates of over-the-counter medications.

The Administrator of Wendigo Pines testified that the Department’s surveyor was disrespectful and rude during the re-inspection, and seemed intent on finding violations. She indicated that employees were unable to find some records due to the stressful situation created by the surveyor. The Administrator also testified that one of her employees overheard the surveyor making fun of the Administrator’s accent while the surveyor was engaged in a telephone conversation.<sup>51</sup> She noted that the prior surveyor who came to the facility in 2005 was much more professional and found far fewer rule violations.<sup>52</sup> Three other Wendigo Pines employees provided letters in which they also asserted that the surveyor was hostile and rude while conducting the re-inspection even though they were cooperative with her and provided the information she requested as quickly as possible.<sup>53</sup> The surveyor testified that she could not recall making fun of the Administrator and denied that she was unprofessional in her approach or demeanor.<sup>54</sup> While it is difficult to assess the validity of the Licensee’s complaints on this limited record, it is suggested that the Department consider assigning a different surveyor to conduct future surveys at Wendigo Pines in order to allay the concerns of the facility about possible bias.

#### **B. L. N.**

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<sup>51</sup> Test. of Kotula.

<sup>52</sup> Test. of Kotula; Ex. 18.

<sup>53</sup> Exs. 9-11.

<sup>54</sup> Test. of Szamatula.